3240 Burnt Mill Drive ◇ Suite 1 ◇ Wilmington, NC 28403 ◇ Tel: 910-790-9500 ◇ Fax: 910-796-8111

CONFIDENTIAL CLIENT INFORMATION

Welcome to the Chrysalis Center. Please complete the front and back of each page to help your clinician provide appropriate services. In accordance with our professional codes of ethics and state and federal law, any information you provide is strictly confidential.

Demographic Information:

Name _____ SSN _____ Date _____

Mailing Address: _____

_____

City: _____ State _____ Zip Code _____

Email Address: _____

Home Phone: _____ Work Phone _____ Cell Phone: _____

What is the best way to contact you? _____ Is it okay to leave a message? Yes No

_____	_____	_____	_____	_____
Date of Birth	Age	Sex	Ethnic Group	Religious Preference

Relationship Status:

Single _____ Cohabitating _____ Married ____ Separated _____ Divorced_____ Widowed ___

Emergency Contact: _____ Telephone: (_____) _____

Parent/Guardian (if relevant): Name: _____

Address: _____ Telephone: (_____) _____

Referral Information:

How did you find out about our services? _____

Employment Information:

Are you currently employed? Yes No

If yes, where are you employed? _____

What is your job title? _____

For Office Use Only: Date of Last Information Update and Initials of Staff Member Completing:

Education Information:
Highest Level of Education Completed:
Grade School _____ High School _____ College ____ Graduate School _____

Are you currently a student? Yes No
If yes, where? _____ Year _____ Major _____

Nutrition Counseling History:
Have you ever met with a nutritionist before? Yes No
If Yes:
Name of nutritionist(s): _____

Presenting problem:_____

When and why did you stop? _____

Health Information:

Please list any chronic illnesses, injuries, physical conditions or disabilities:_____

_____

_____

Allergies/Adverse Reactions to Treatment:_____

_____

Primary Care Physician Name: _____

Telephone: (_____) _____ Address: _____

_____

Current Medications

Supplements & Vitamins	Daily Dose	Start Date	Name of Prescriber

Weight and Exercise History

How tall are you? _____ Current Weight _____ Desired Weight _____

Lowest Weight _____ Date/age of this weight_____

Highest Weight _____ Date/age of this weight_____

How often do you weigh yourself? _____

Briefly describe any diets you have tried and how long you followed them:

Briefly describe your exercise habits (current and past):

Please list any nutrition/eating pattern/exercise goals that you hope to achieve as a result of nutritional counseling. Also please include any other information when you feel would be helpful.

Check below if you or any family member(s) are currently experiencing or have experienced any of the following?

	Self	Family		Self	Family
Anemia			Alcohol Abuse		
Hypoglycemia			Drug Abuse		
Diabetes			Sexual Abuse		
High Blood Pressure			Emotional Abuse		
High Cholesterol			Physical Abuse		
Heart Disease			Rape		
Irritable Bowel			Stealing / Shoplifting		
Diverticulitis			Chronic Health Problems		
Intestinal Problems			Workaholism		
Cancer			Anxiety/ Panic Disorder		
Anorexia Nervosa			Depression		
Bulimia Nervosa			Mood Swings		
Binge Eating			Bipolar Disorder		
Obesity			Emotional Problems		
Laxative/Diuretic Use			Nervous Breakdown		
Compulsive Overeating			Suicide or attempt		
Other			Psychiatric Hospitalization		

Food Allergies:

Food Intolerances:

Foods Avoided:

Is there any other relevant information that we have not asked about?

Chrysalis
Center for Counseling
and Eating Disorder Treatment

**Insurance is filed as a courtesy. All unpaid balances will be the responsibility of the client. It is the client's responsibility to notify Chrysalis of any information that has changed.*

INSURANCE INFORMATION

Client Information:

Full Name (Including Middle): _____

Address: _____

Telephone: _____

Birth Date: _____

Social Security Number: _____

Relationship to Policy Holder: _____

Primary Insurance Information (family member whose insurance you are covered by):

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address: _____

_____

Policy Holder's Telephone: _____

_____

Policy Holder's Birth Date: _____

_____

Policy Holder's Social Security Number: _____

Employer's Name: _____

Insurance Plan Name: _____

Subscriber Number or Member ID Number: _____

_____

Group Number: _____

* Please see reverse side for secondary insurance information and consenting signature.

Secondary Insurance Information (If applicable):

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address: _____

_____

Policy Holder's Telephone: _____

Policy Holder's Birth Date: _____

Policy Holder's Social Security Number: _____

Employer's Name: _____

Insurance Plan Name: _____

Subscriber Number or Member ID Number: _____

Group Number: _____

I have read and completed the information above and verify that it is correct. I understand that it is my responsibility to update Chrysalis with any change in insurance information.

_____ _____

Name of Client (printed) Date

_____

Signature